NOTICE OF INDEPENDENT REVIEW DECISION

April 10, 2002

Requestor Respondent

RE: Injured Worker:
MDR Tracking #: M2-02-0482-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in neurosurgery, which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

The ___ physician reviewer has determined that the anterior cervical discectomy at C4-5, C5-6, and C6-7 is not medically necessary for treatment of the patient's condition. Therefore, ___ agrees with the previous adverse determination. The specific reasons including the clinical basis for this determination are as follows:

This 51-year-old male has been described as having severe pain in his neck and shoulders since an on-the-job injury in ___. Specifically the patient complains of numbness and tingling in both hands, mainly in the ring and small fingers. He denies any radiating arm pain. The patient has no bowel or bladder dysfunction. Conservative treatment including multiple cervical epidural steroid injections, physical therapy and exercise has been ineffective. The patient complains of bilateral weakness in his hands. He also describes interscapular pain and pain in his shoulder blades. This pain is characterized as moderately severe and interfering with sleep and worsening with cough or sneezing. The neurologic examination showed tenderness with rotation of the neck to the right and left. Motor examination was intact in the upper and lower extremities. There were no Horner's, Hoffman's or Babinski signs or hyperflexia with clonus. The left knee reflex was +1 in comparison to the right. The patient had markedly positive Tinel's at both elbows, greater to the left than to the right and Tinel sign at both wrists. The patient underwent an electromyelogram on 11/14/01. The nerve conduction studies showed dramatic delay of conduction across both elbows, each being equally delayed and compatible with a diagnosis of bilateral ulnar neuropathy at both elbows. The needle EMG samplings of all muscles of the upper extremities tested were entirely within normal limits; therefore, not diagnostic for radiculopathy. An electromyelogram report performed on 07/17/01 showed advanced degenerative disc disease, particularly at C5-6 with a broad based spondylitic protrusion on bony bar at the C5-C6 level. This caused central canal stenosis as well as bilateral foraminal stenosis. In addition, there was a small, mildly compressive focal central disc protrusion or herniation noted at C6-7. The diagnosis of bilateral ulnar palsy is well established symptomatically, objectively on examination and objectively on nerve conduction studies and the decompression of both ulnar nerves at the elbow is clearly indicated. However, in terms of the patient's cervical spine, the findings noted on the MRI scan are not related to the compensable injury. In terms of cervical myelopathy or radiculopathy, there is no clinical evidence by history, by physical

examination or by electromyelogram of radiculopathy. Therefore, it is determined that the anterior cervical discectomy at C4-5, C5-6 and C6-7 is not medically necessary to treat this patient's condition.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code '148.3). This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code '102.4(h) or 102.5(d)). A request for hearing, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, Texas 78704-0012.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

cc: Injured Worker
David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 10th day of April 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: